WSR 15-05-008

PERMANENT RULES

HEALTH CARE AUTHORITY

(Washington Apple Health)

[Filed February 5, 2015, 2:57 p.m., effective March 8, 2015]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The agency is updating language to include treatment for life-threatening benign tumors. The updated language reflects the original intent of the rule.

Citation of Existing Rules Affected by this Order: Amending WAC 182-507-0120 Alien medical for dialysis and cancer treatment.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Adopted under notice filed as WSR 15-01-186 on December 23, 2014.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 1, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 1, Repealed 0.

Date Adopted: February 5, 2015.

Jason R. P. Crabbe
Rules Coordinator

AMENDATORY SECTION (Amending WSR 12-24-038, filed 11/29/12, effective 12/30/12)

WAC 182-507-0120 Alien medical for dialysis and cancer treatment, and treatment of life-threatening benign tumors. In addition to the provisions for emergency care described in WAC 182-507-0115, the medicaid agency also considers the conditions in this section as an emergency, as defined in WAC 182-500-0030.

(1) A person nineteen years of age or older who is not pregnant and meets the eligibility criteria under WAC 182-507-0110 may be eligible for the scope of service categories under this program if the condition requires:

(a) Surgery, chemotherapy, and/or radiation therapy to treat cancer or life-threatening benign tumors;

(b) Dialysis to treat acute renal failure or end stage renal disease (ESRD); or

(c) Anti-rejection medication, if the person has had an organ transplant.

(2) When related to treating the qualifying medical condition, covered services include but are not limited to:

(a) Physician and ARNP services, except when providing a service that is not within the scope of this medical program (as described in subsection (7) of this section);

(b) Inpatient and outpatient hospital care;

(c) Dialysis;

(d) Surgical procedures and care;

(e) Office or clinic based care;

(f) Pharmacy services;

(g) Laboratory, X ray, or other diagnostic studies;

(h) Oxygen services;

(i) Respiratory and intravenous (IV) therapy;

(j) Anesthesia services;

(k) Hospice services;

(l) Home health services, limited to two visits;

(m) Durable and nondurable medical equipment;

(n) Nonemergency transportation; and

(o) Interpreter services.

(3) All hospice, home health, durable and nondurable medical equipment, oxygen and respiratory, IV therapy, and dialysis for acute renal disease services require prior authorization. Any prior authorization requirements applicable to the other services listed above must also be met according to specific program rules.

(4) To be qualified and eligible for coverage for cancer treatment or treatment of life-threatening benign tumors under this program, the diagnosis must be already established or confirmed. There is no coverage for cancer screening or diagnostics for a workup to establish the presence of cancer or life-threatening benign tumors.

(5) Coverage for dialysis under this program starts the date the person begins dialysis treatment, which includes fistula placement and other required access. There is no coverage for diagnostics or predialysis intervention, such as surgery for fistula placement anticipating the need for dialysis, or any services related to preparing for dialysis.

(6) Certification for eligibility will range between one to twelve months depending on the qualifying condition, the proposed treatment plan, and whether the client is required to meet a spenddown liability.

(7) The following are not within the scope of service categories for this program:

(a) Cancer screening or work-ups to detect or diagnose the presence of cancer or life-threatening benign tumors;

(b) Fistula placement while the person waits to see if dialysis will be required;

(c) Services provided by any health care professional to treat a condition not related to, or medically necessary to, treat the qualifying condition;

(d) Organ transplants, including preevaluations and post operative care;

(e) Health department services;

(f) School-based services;

(g) Personal care services;

(h) Physical, occupational, and speech therapy services;

(i) Audiology services;

(j) Neurodevelopmental services;

(k) Waiver services;

(l) Nursing facility services;

(m) Home health services, more than two visits;

(n) Vision services;

(o) Hearing services;

(p) Dental services, unless prior authorized and directly related to dialysis or cancer treatment;

(q) Mental health services;

(r) Podiatry services;

(s) Substance abuse services; and

(t) Smoking cessation services.

(8) The services listed in subsection (7) of this section are not within the scope of service categories for this program. The exception to rule process is not available.

(9) Providers must not bill the agency for visits or services that do not meet the qualifying criteria described in this section.

WSR 15-05-010
PERMANENT RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Economic Services Administration)

[Filed February 5, 2015, 3:43 p.m., effective March 8, 2015]

Effective Date of Rule: Thirty-one days after filing.

Purpose: This department is amending WAC 388-414-0001 to fully incorporate requirements under Title 7 of the Code of Federal Regulations (C.F.R.) §273.2(j) related to categorical eligibility (CE) for the federal supplemental nutrition assistance program (SNAP) and the requirement to verify residency if questionable at application and recertification for certain households.

The department is also amending WAC 388-468-0005 to clarify that households considered CE based on the receipt of noncash public assistance benefits (broad-based CE) have the same state residency verification requirements as non-CE households and both household types can be out-of-state for more than one month and still be considered state residents.

Citation of Existing Rules Affected by this Order: WAC 388-414-0001 Do I have to meet all eligibility requirements for Basic Food? and 388-468-0005 Residency.

Statutory Authority for Adoption: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090.

Other Authority: 7 C.F.R. 273.2 and 273.3.

Adopted under notice filed as WSR 15-01-049 on December 9, 2014.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 2, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 2, Repealed 0.

Date Adopted: February 4, 2015.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 14-15-070, filed 7/15/14, effective 8/15/14)

WAC 388-414-0001 Do I have to meet all eligibility requirements for Basic Food? (1) **What is "categorically eligible" (CE)?**

(a) Being categorically eligible (CE) means that you have already met requirements for the program. If you are CE, you do not have to meet **every** program requirement to be eligible for Basic Food.

(b) If your assistance unit (AU) is CE, you automatically meet the following requirements for Basic Food:

(i) ((~~Residency under WAC 388-468-0005;~~

~~(ii)~~)) Countable resource limit under WAC 388-470-0005;

(((~~iii~~))) (ii) Maximum gross monthly income under WAC 388-478-0060; and

(((~~iv~~))) (iii) Maximum net monthly income under WAC 388-478-0060.

(c) If your AU is CE and the information is available from another program, you do not need to provide the following for Basic Food:

(i) Social Security number information under WAC 388-476-0005; ((~~and~~))

(ii) Sponsored alien information under WAC 388-450-0155; and

(iii) Residency under WAC 388-468-0005.

(d) Being CE does not mean that your AU is guaranteed to get Basic Food benefits. If your AU is CE:

(i) You must still meet the other Basic Food program requirements under WAC 388-400-0040; and

(ii) If you meet the other program requirements, we must budget your AU's income to determine the amount of benefits your AU will receive.

(2) **Who is categorically eligible for Basic Food?** Your Basic Food AU is CE when your household meets the conditions in subsection (2)(a) or (2)(b) below:

(a) Your AU's income that we do not exclude under WAC 388-450-0015 is at or under two hundred percent of the federal poverty guidelines we use for department programs.

(i) The federal government publishes the federal poverty guidelines on the health and human services web site. These are currently posted at http://aspe.hhs.gov/poverty/index.shtml.

(ii) The department uses the monthly value of the income guidelines for the current year beginning the first of April every year.

(iii) If your income is not over two hundred percent of the federal poverty guidelines, we provide your AU information about the department programs and resources in the community.

(b) Everyone in your AU receives one of the following cash assistance programs:

(i) Temporary assistance for needy families (TANF)/ state family assistance (SFA) or Tribal TANF under WAC 388-400-0005 and WAC 388-400-0010;

(ii) Aged, blind, or disabled (ABD) cash assistance under WAC 388-400-0060;

(iii) Supplemental security income (SSI) under Title XVI of the Social Security Act; or

(iv) Diversion cash assistance (DCA) under WAC 388-432-0005. DCA makes the Basic Food AU CE for the month it receives DCA and the following three months.

(3) **Who is not CE even if my AU meets the above criteria?**

(a) Even if your AU is CE, members of your AU are not eligible for Basic Food if they:

(i) Are not eligible because of their alien or student status;

(ii) Were disqualified from Basic Food under WAC 388-444-0055 for failing work requirements;

(iii) Are not eligible for failing to provide or apply for a Social Security number;

(iv) Receive SSI in a cash-out state (state where SSI payments are increased to include the value of the client's food stamp allotment); or

(v) Live in an institution not eligible for Basic Food under WAC 388-408-0040.

(b) If a person in your AU is not eligible for Basic Food, we do not include them as an **eligible member** of your CE AU.

(c) Your AU is not CE if:

(i) Your AU is not eligible because of striker requirements under WAC 388-480-0001;

(ii) Your AU is ineligible for knowingly transferring countable resources in order to qualify for benefits under WAC 388-488-0010;

(iii) Your AU refused to cooperate in providing information that is needed to determine your eligibility;

(iv) The head of household for your AU failed to meet work requirements; or

(v) Anyone in your AU is disqualified because of an intentional program violation under WAC 388-446-0015.

AMENDATORY SECTION (Amending WSR 12-10-042, filed 4/27/12, effective 6/1/12)

WAC 388-468-0005 Residency. Subsections (1) through (4) applies to cash, the Basic Food program, and medical programs.

(1) A resident is a person who:

(a) Currently lives in Washington and intends to continue living here permanently or for an indefinite period of time; or

(b) Entered the state looking for a job; or

(c) Entered the state with a job commitment.

(2) A person does not need to live in the state for a specific period of time to be considered a resident.

(3) A child under age eighteen is a resident of the state where the child's primary custodian lives.

(4) ((~~With the exception of subsection (5) of this section, a~~)) A client can temporarily be out of the state for more than one month. If so, the client must supply the department with adequate information to demonstrate the intent to continue to reside in the state of Washington.

(5) ((~~Basic Food program assistance units who are not categorically eligible do not meet residency requirements if they stay out of the state more than one calendar month.~~

~~(6)~~)) A client may not receive comparable benefits from another state for the cash and Basic Food programs.

(((~~(7)~~))) (6) A former resident of the state can apply for the ABD cash program while living in another state if:

(a) The person:

(i) Plans to return to this state;

(ii) Intends to maintain a residence in this state; and

(iii) Lives in the United States at the time of the application.

(b) In addition to the conditions in subsection (((~~(7)~~))) (6)(a)(i), (ii), and (iii) being met, the absence must be:

(i) Enforced and beyond the person's control; or

(ii) Essential to the person's welfare and is due to physical or social needs.

(c) See WAC 388-406-0035, 388-406-0040, and 388-406-0045 for time limits on processing applications.

(((~~(8)~~))) (7) Residency is not a requirement for detoxification services.

(((~~(9)~~))) (8) A person is not a resident when the person enters Washington state only for medical care. This person is not eligible for any medical program. The only exception is described in subsection (((~~(10)~~))) (9) of this section.

(((~~(10)~~))) (9) It is not necessary for a person moving from another state directly to a nursing facility in Washington state to establish residency before entering the facility. The person is considered a resident if they intend to remain permanently or for an indefinite period unless placed in the nursing facility by another state.

(((~~(11)~~))) (10) For purposes of medical programs, a client's residence is the state:

(a) Paying a state supplemental security income (SSI) payment; or

(b) Paying federal payments for foster or adoption assistance; or

(c) Where the noninstitutionalized individual lives when medicaid eligibility is based on blindness or disability; or

(d) Where the parent or legal guardian, if appointed, for an institutionalized:

(i) Minor child; or

(ii) Client twenty-one years of age or older, who became incapable of determining residential intent before reaching age twenty-one.

(e) Where a client is residing if the person becomes incapable of determining residential intent after reaching twenty-one years of age; or

(f) Making a placement in an out-of-state institution; or

(g) For any other institutionalized individual, the state of residence is the state where the individual is living with the intent to remain there permanently or for an indefinite period.

(((~~(12)~~))) (11) In a dispute between states as to which is a person's state of residence, the state of residence is the state in which the person is physically located.

Reviser's note: The typographical error in the above section occurred in the copy filed by the agency and appears in the Register pursuant to the requirements of RCW 34.08.040.

WSR 15-05-014
PERMANENT RULES
STATE BOARD OF HEALTH

[Filed February 6, 2015, 10:58 a.m., effective March 9, 2015]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The purpose of the rule is to update references to the Control of Communicable Diseases Manual. As a result the board's rules will reflect best current practices for infectious disease control. The rule revision will clarify the board's intent to encourage local health jurisdictions to establish interagency agreements in advance of health emergencies so that disease control measures may be more easily and uniformly implemented.

Citation of Existing Rules Affected by this Order: Amending WAC 246-100-036, 246-100-021, and 246-215-02245.

Statutory Authority for Adoption: RCW 43.20.050.

Adopted under notice filed as WSR 14-24-093 on December 1, 2014.

Changes Other than Editing from Proposed to Adopted Version: The adopted version does not include WAC 246-138-030 which is outside of board of health authority.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 3, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 3, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 3, Repealed 0.

Date Adopted: January 14, 2015.

Michelle A. Davis
Executive Director

AMENDATORY SECTION (Amending WSR 00-23-120, filed 11/22/00, effective 12/23/00)

WAC 246-100-021 Responsibilities and duties—Health care providers. Every health care provider, as defined in chapter 246-100 WAC, shall:

(1) Provide adequate, understandable instruction in control measures designed to prevent the spread of disease to:

(a) Each patient with a communicable disease under his or her care; and

(b) Others as appropriate to prevent spread of disease.

(2) Cooperate with public health authorities during investigation of:

(a) Circumstances of a case or suspected case of a notifiable condition or other communicable disease; and

(b) An outbreak or suspected outbreak of illness.

Comply with requirements in WAC 246-100-206, 246-100-211, and chapter 246-101 WAC.

(3) Use protocols established in the *Control of Communicable Diseases Manual*, ((~~seventeenth edition, James Chin, MD, MPH, editor, 2000~~)) 20th edition, published by the American Public Health Association, when treating wounds caused by animal bites. A copy of this publication is available for review at the department and at each local health department.

AMENDATORY SECTION (Amending WSR 03-17-022, filed 8/13/03, effective 9/13/03)

WAC 246-100-036 Responsibilities and duties—Local health officers. (1) The local health officer shall establish, in consultation with local health care providers, health facilities, emergency management personnel, law enforcement agencies, and any other entity he or she deems necessary, plans, policies, and procedures for instituting emergency measures necessary to prevent the spread of communicable disease or contamination.

(2) Local health officers shall:

(a) Notify health care providers within the health district regarding requirements in this chapter;

(b) Ensure anonymous HIV testing is reasonably available;

(c) Make HIV testing, AIDS counseling, and pretest and post-test counseling, as defined in this chapter, available for voluntary, mandatory, and anonymous testing and counseling as required by RCW 70.24.400;

(d) Make information on anonymous HIV testing, AIDS counseling, and pretest and post-test counseling, as described under WAC 246-100-208 and 246-100-209, available;

(e) Use identifying information on HIV-infected individuals provided according to chapter 246-101 WAC only:

(i) For purposes of contacting the HIV-positive individual to provide test results and post-test counseling; or

(ii) To contact persons who have experienced substantial exposure, including sex and injection equipment-sharing partners, and spouses; or

(iii) To link with other name-based public health disease registries when doing so will improve ability to provide needed care services and counseling and disease prevention; and

(f) Destroy documentation of referral information established in WAC 246-100-072 and this subsection containing identities and identifying information on HIV-infected individuals and at-risk partners of those individuals immediately after notifying partners or within three months, whichever occurs first.

(3) Local health officers shall, when necessary, conduct investigations and institute disease control and contamination control measures, including medical examination, testing, counseling, treatment, vaccination, decontamination of persons or animals, isolation, quarantine, vector control, condemnation of food supplies, and inspection and closure of facilities, consistent with those indicated in the ((~~17th edition, 2000 of the~~)) *Control of Communicable Diseases Manual*, 20th edition, published by the American Public Health Association, or other measures he or she deems necessary based

on his or her professional judgment, current standards of practice and the best available medical and scientific information.

(4) A local health department ((~~may make agreements~~)) should seek agreements as necessary with tribal governments, with federal authorities or with state agencies or institutions of higher education that empower the local health officer to conduct investigations and institute control measures in accordance with WAC 246-100-040 on tribal lands, federal enclaves and military bases, and the campuses of state institutions. State institutions include, but are not limited to, state-operated colleges and universities, schools, hospitals, prisons, group homes, juvenile detention centers, institutions for juvenile delinquents, and residential habilitation centers.

AMENDATORY SECTION (Amending WSR 13-03-109, filed 1/17/13, effective 5/1/13)

WAC 246-215-02245 Employee health—Removal of exclusion or restriction based on diagnosis. Except as specified under WAC 246-215-02250, the PERSON IN CHARGE shall obtain approval from the LOCAL HEALTH OFFICER before reinstating a FOOD EMPLOYEE who was RESTRICTED or EXCLUDED based on:

(1) The ((~~19th edition of the~~)) *Control of Communicable Diseases Manual*, 20th edition, published by the American Public Health Association; or

(2) Other measures the LOCAL HEALTH OFFICER deems necessary based on his or her professional judgment, current standards of practice and the best available medical and scientific information.

WSR 15-05-020
PERMANENT RULES
HEALTH CARE AUTHORITY
(Washington Apple Health)

[Filed February 9, 2015, 11:11 a.m., effective March 12, 2015]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The agency is modifying when a change in a rural health clinic's services constitutes a change in scope of services.

Citation of Existing Rules Affected by this Order: Amending WAC 182-549-1500.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Adopted under notice filed as WSR 15-01-188 on December 23, 2014.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 1, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 1, Repealed 0.

Date Adopted: February 9, 2015.

Jason R. P. Crabbe
Rules Coordinator

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-549-1500 Rural health clinics—Change in scope of service rate adjustment. (((~~(1) For clinics reimbursed under the prospective payment system (PPS), the department considers a rural health clinic's (RHC) change in scope of service to be a change in the type, intensity, duration, and/or amount of services provided by the RHC. Changes in scope of service apply only to covered medicaid services.~~

~~(a) When the department determines that a change in scope of service has occurred after the base year, the department will adjust the RHC's encounter rate to reflect the change.~~

~~(b) RHCs must:~~

~~(i) Notify the department's RHC program manager in writing, at the address published in the department's rural health clinic billing instructions, of any changes in scope of service no later than sixty days after the effective date of the change; and~~

~~(ii) Provide the department with all relevant and requested documentation pertaining to the change in scope of service.~~

~~(c) The department adjusts the encounter rate to reflect the change in scope of service using one or more of the following:~~

~~(i) A medicaid comprehensive desk review of the RHC's cost report;~~

~~(ii) Review of a medicare audit of the RHC's cost report; or~~

~~(iii) Other documentation relevant to the change in scope of service.~~

~~(d) The adjusted encounter rate will be effective on the date the change of scope of service is effective.~~

~~(2) For clinics reimbursed under the alternative payment methodology (APM), the department considers an RHC change in scope of service to be a change in the type of services provided by the RHC. The department addresses changes in intensity, duration, and/or amount of services in the next scheduled encounter rate rebase. Changes in scope of service apply only to covered medicaid services.~~

~~(a) When the department determines that a change in scope of service has occurred after the base year, the department adjusts the RHC's encounter rate to reflect the change.~~

~~(b) RHCs must:~~

~~(i) Notify the department's RHC program manager in writing, at the address published in the department's rural health clinic billing instructions, of any changes in scope of~~

~~service no later than sixty calendar days after the effective date of the change; and~~

~~(ii) Provide the department with all relevant and requested documentation pertaining to the change in scope of service.~~

~~(c) The department adjusts the encounter rate to reflect the change in scope of service using one or more of the following:~~

~~(i) A medicaid comprehensive desk review of the RHC's cost report;~~

~~(ii) Review of a medicare audit of the RHC's cost report, if available; or~~

~~(iii) Other documentation relevant to the change in scope of service.~~

~~(d) The adjusted encounter rate will be effective on the date the change of scope of service is effective.~~)) In accordance with 42 U.S.C. 1396a (bb)(3)(B), the agency will adjust its payment rate to a rural health clinic (RHC) to take into account any increase or decrease in the scope of the RHC's services. The procedures and requirements for any such rate adjustment are described below.

(1) **Triggering events.**

(a) An RHC may file a change in scope of services rate adjustment application on its own initiative only when:

(i) The cost to the RHC of providing covered health care services to eligible clients has increased due to one or more of the following:

(A) A change in the type of health care services the RHC provides;

(B) A change in the intensity of health care services the RHC provides. Intensity means the total quantity of labor and materials consumed by an individual client during an average encounter has increased;

(C) A change in the duration of health care services the RHC provides. Duration means the length of an average encounter has increased;

(D) A change in the amount of health care services the RHC provides in an average encounter;

(E) Any change comparable to (a)(i)(A) through (D) of this subsection in which the type, intensity, duration or amount of services has decreased and the cost of an average encounter has decreased; and

(ii) The cost change equals or exceeds:

(A) An increase of one and three-quarters percent in the prospective payment system (PPS) rate per encounter over one year as measured by comparing the cost per encounter to the then current PPS rate;

(B) A decrease of two and one-half percent in the PPS rate per encounter over one year as measured by comparing the cost per encounter to the then current PPS rate; or

(C) A cumulative increase or decrease of five percent in the PPS rate per encounter as compared to the current year's cost per encounter; and

(iii) The costs reported to the agency to support the proposed change in scope rate adjustment are reasonable under state and federal law.

(b) At any time, the agency may instruct the RHC to file a cost report with a statement of whether the RHC asserts that its PPS rate should be increased or decreased due to a change in the scope of services (the RHC "position statement").

(i) The RHC must file a completed cost report and position statement no later than ninety calendar days after receiving the instruction from the agency to file an application;

(ii) The RHC's cost report and position statement will be reviewed under the same criteria listed above for an application for a change in scope adjustment;

(iii) The agency will not request more than one change in scope in a calendar year.

(2) **Filing requirements.**

(a) The RHC may apply for a prospective change in scope of service rate adjustment, a retrospective change in scope of service rate adjustment, or both, in a single application.

(i) Unless instructed to file an application by the agency, the RHC may file no more than one change in scope of service application per calendar year; however, more than one type of change in scope may be included in a single application.

(ii) The RHC must file for a change in scope of service rate adjustment no later than ninety days after the end of the calendar year in which the RHC believes the change in scope occurred or in which the RHC learned that the cost threshold in subsection (1)(a)(ii) of this section was met, whichever is later.

(b) Prospective change in scope.

(i) To file a prospective change in scope of service rate adjustment application, the RHC must submit projected costs sufficient to establish an interim rate. A prospective change is a change the RHC plans to implement in the future. The interim rate adjustment will go into effect after the change takes effect.

(ii) The interim rate is subject to the post change in scope review and rate adjustment process defined in subsection (5) of this section.

(iii) If the change in scope occurs fewer than ninety days after the RHC submitted a complete application to the agency, the interim rate must take effect no later than ninety days after the complete application was submitted to the agency.

(iv) If the change in scope occurs more than ninety days but fewer than one hundred eighty days after the RHC submitted a complete application to the agency, the interim rate takes effect when the change in scope occurs.

(v) If the RHC fails to implement a change in service identified in its prospective change in scope of service rate adjustment application within one hundred eighty days, the application is void and the RHC may resubmit the application to the agency, in which case, (a)(i) of this subsection does not apply.

(c) Retrospective change in scope.

(i) A retrospective change in scope of service rate adjustment application must state each qualifying event listed in subsection (1)(a)(i) of this section that supports its application and include twelve months of data documenting the cost change caused by the qualifying event. A retrospective change in scope is a change that took place in the past and the RHC is seeking to adjust its rate based on that change.

(ii) If approved, a retrospective rate adjustment takes effect on the date the RHC filed the application with the agency.

(3) **Supporting documentation.**

(a) To apply for a change in scope of service rate adjustment, the RHC must include the following documentation in the application:

(i) A narrative description of the proposed change in scope;

(ii) A description of each cost center on the cost report that was or will be affected by the change in scope;

(iii) The RHC's most recent audited financial statements, if audit is required by federal law;

(iv) The implementation date for the proposed change in scope; and

(v) Any additional documentation requested by the agency.

(b) A prospective change in scope of service rate adjustment application must also include projected medicare cost report with supplemental schedules necessary to identify the medicaid cost per visit for the twelve-month period following implementation of the change in scope.

(c) A retrospective change in scope of service rate adjustment application must also include the medicare cost report with supplemental schedules necessary to identify the medicaid cost per visit and encounter data for twelve months or the fiscal year following implementation of the proposed change in scope.

(4) **Review of the application.**

(a) Application processing.

(i) The agency must review the application for completeness, accuracy, and compliance with program rules.

(ii) Within sixty days of receiving the application, the agency must notify the RHC of any deficient documentation or request any additional information that is necessary to process the application.

(iii) Within ninety days of receiving a complete application, the agency must send the RHC:

(A) A decision stating whether it will implement a PPS rate change; and

(B) A rate-setting statement.

(iv) Failure to act within ninety days will mean that the change is considered denied by the agency and the RHC may appeal the decision as provided for in subsection (6) of this section.

(b) Determining rate for change in scope.

(i) The agency must set an interim rate for prospective changes in scope by adjusting the RHC's existing rate by the projected average cost per encounter of any approved change. The agency will review the costs to determine if they are reasonable, and set a new interim rate based on the determined cost per encounter.

(ii) The agency must set an adjusted encounter rate for retrospective changes in scope by adjusting the RHC's existing rate by the documented average cost per encounter of the approved change. Projected costs per encounter may be used if there are insufficient historical data to establish the rate. The agency will review the costs to determine whether they are reasonable, and set a new rate based on the determined cost per encounter.

(c) If the RHC is paid under an alternative payment methodology (APM), any change in scope of service rate adjustment requested by the RHC will modify the PPS rate in addition to the APM.

(d) The agency may delegate the duties related to application processing and rate setting to a third party. The agency retains final authority for making decisions related to changes in scope.

(5) **Post change in scope of services rate adjustment review.**

(a) If the change in scope application was based on a year or more of actual encounter data, the agency may conduct a post change in scope rate adjustment review.

(b) If the change in scope application was based on less than a full year of actual encounter data, the RHC must submit the following information to the agency within eighteen months of the effective date of the rate adjustment:

(i) Medicare cost report with supplemental schedules necessary to identify the medicaid cost per visit and encounter data for twelve consecutive months of experience following implementation of the change in scope; and

(ii) Any additional documentation requested by the agency.

(c) The agency will conduct the post change in scope review within ninety days of receiving the cost report and encounter data from the RHC.

(d) If necessary, the agency will adjust the encounter rate within ninety days to ensure that the rate reflects the reasonable cost of the change in scope of services.

(e) A rate adjustment based on a post change in scope review will take effect on the date the agency issues its adjustment. The new rate will be prospective.

(f) If the RHC fails to submit the post change in scope cost report or related encounter data, the agency must provide written notice to the clinic of the deficiency within thirty days.

(g) If the RHC fails to submit required documentation within five months of this deficiency notice, the agency may reinstate the prechange in scope encounter rate going forward from the date the interim rate was established. Any overpayment to the RHC may be recouped by the agency.

(6) **Appeals.** Appeals of agency action under this section are governed by WAC 182-502-0220, except that any rate change begins on the date the agency received the change in scope of services rate adjustment application.

WSR 15-05-023

PERMANENT RULES

HEALTH CARE AUTHORITY

(Washington Apple Health)

[Filed February 9, 2015, 2:40 p.m., effective March 12, 2015]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The agency is modifying when a change in a federally qualified health center's services constitutes a change in the scope of services.

Citation of Existing Rules Affected by this Order: Amending WAC 182-548-1500.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Adopted under notice filed as WSR 15-01-187 on December 23, 2014.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 1, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 1, Repealed 0.

Date Adopted: February 9, 2015.

Jason R. P. Crabbe
Rules Coordinator

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-548-1500 Federally qualified health centers—Change in scope of service rate adjustment. (((~~(1) For centers reimbursed under the prospective payment system (PPS), the department considers a federally qualified health center (FQHC) change in scope of service to be a change in the type, intensity, duration, and/or amount of services provided by the FQHC. Changes in scope of service apply only to covered medicaid services.~~

~~(2) When the department determines that a change in scope of service has occurred after the base year, the department adjusts the FQHC's encounter rate to reflect the change.~~

~~(3) FQHCs must:~~

~~(a) Notify the department's FQHC program manager in writing, at the address published in the department's federally qualified health centers billing instructions, of any changes in scope of service no later than sixty calendar days after the effective date of the change; and~~

~~(b) Provide the department with all relevant and requested documentation pertaining to the change in scope of service.~~

~~(4) The department adjusts the encounter rate to reflect the change in scope of service using one or more of the following:~~

~~(a) A medicaid comprehensive desk review of the FQHC's cost report;~~

~~(b) Review of a medicare audit of the FQHC's cost report; or~~

~~(c) Other documentation relevant to the change in scope of service.~~

~~(5) The adjusted encounter rate will be effective on the date the change of scope of service is effective.~~

~~(6) For centers reimbursed under the alternative payment methodology (APM), the department considers an FQHC change in scope of service to be a change in the type of services provided by the FQHC. Changes in intensity, duration, and/or amount of services will be addressed in the next scheduled encounter rate rebase. Changes in scope of service apply only to covered medicaid services.~~

~~(7) When the department determines that a change in scope of service has occurred after the base year, the department adjusts the FQHC's encounter rate to reflect the change.~~

~~(8) FQHCs must:~~

~~(a) Notify the department's FQHC program manager in writing, at the address published in the department's FQHC billing instructions, of any changes in scope of service no later than sixty calendar days after the effective date of the change; and~~

~~(b) Provide the department with all relevant and requested documentation pertaining to the change in scope of service.~~

~~(9) The department adjusts the encounter rate to reflect the change in scope of service using one or more of the following:~~

~~(a) A medicaid comprehensive desk review of the FQHC's cost report;~~

~~(b) Other documentation relevant to the change in scope of service.~~

~~(10) The adjusted encounter rate will be effective on the date the change of scope of service is effective.~~)) In accordance with 42 U.S.C. 1396a (bb)(3)(B), the agency will adjust its payment rate to a federally qualified health center (FQHC) to take into account any increase or decrease in the scope of the FQHC's services. The procedures and requirements for any such rate adjustment are described below.

(1) **Triggering events.**

(a) An FQHC may file a change in scope of services rate adjustment application on its own initiative only when:

(i) The cost to the FQHC of providing covered health care services to eligible clients has increased due to one or more of the following:

(A) A change in the type of health care services the FQHC provides;

(B) A change in the intensity of health care services the FQHC provides. Intensity means the total quantity of labor and materials consumed by an individual client during an average encounter has increased;

(C) A change in the duration of health care services the FQHC provides. Duration means the length of an average encounter has increased;

(D) A change in the amount of health care services the FQHC provides in an average encounter;

(E) Any change comparable to (a)(i)(A) through (D) of this subsection in which the type, intensity, duration or amount of services has decreased and the cost of an average encounter has decreased; and

(ii) The cost change equals or exceeds:

(A) An increase of one and three-quarters percent in the prospective payment system (PPS) rate per encounter over one year as measured by comparing the cost per encounter to the then current PPS rate;

(B) A decrease of two and one-half percent in the PPS rate per encounter over one year as measured by comparing the cost per encounter to the then current PPS rate; or

(C) A cumulative increase or decrease of five percent in the PPS rate per encounter as compared to the current year's cost per encounter; and

(iii) The costs reported to the agency to support the proposed change in scope rate adjustment are reasonable under OMB *Circular A-122* or successor (the *Uniform Grants Guidance*) and other applicable state and federal law.

(b) At any time, the agency may instruct the FQHC to file a medicaid cost report with a statement of whether the FQHC asserts that its PPS rate should be increased or decreased due to a change in the scope of services (the FQHC "position statement").

(i) The FQHC must file a completed cost report and position statement no later than ninety calendar days after receiving the instruction from the agency to file same; provided, however, if the FQHC has recently completed its fiscal year at the time of the agency's request but has not received its annual audit by the time of the request, the FQHC may at its option wait and respond to the agency's request ninety days after the FQHC receives its annual audit or it may submit a cost report based on the prior year's audit.

(ii) The FQHC's cost report and position statement will be reviewed under the same criteria listed above for an application for a change in scope adjustment.

(iii) The agency will not request more than one change in scope in a calendar year.

(2) **Filing requirements.**

(a) The FQHC may apply for a prospective change in scope of service rate adjustment, a retrospective change in scope of service rate adjustment, or both, in a single application.

(i) Unless instructed to file an application by the agency, the FQHC may file no more than one change in scope of service application per calendar year; however, more than one type of change in scope may be included in a single application.

(ii) The FQHC must file for a change in scope of service rate adjustment no later than ninety days after the end of the calendar year in which the FQHC believes the change in scope occurred or in which the FQHC learned based on its annual audit that the cost threshold in subsection (1)(a)(ii) of this section was met, whichever is later.

(b) Prospective change in scope.

(i) To file a prospective change in scope of service rate adjustment application, the FQHC must submit projected costs sufficient to establish an interim rate. A prospective change is a change the FQHC plans to implement in the future. The interim rate adjustment will go into effect after the change takes effect.

(ii) The interim rate is subject to the post change in scope review and rate adjustment process defined in subsection (5) of this section.

(iii) If the change in scope occurs fewer than ninety days after the FQHC submitted a complete application to the agency, the interim rate must take effect no later than ninety days after the complete application was submitted to the agency.

(iv) The change in scope occurs more than ninety days but fewer than one hundred eighty days after the FQHC submitted a complete application to the agency, the interim rate takes effect when the change in scope occurs.

(v) If the FQHC fails to implement a change in service identified in its prospective change in scope of service rate adjustment application within one hundred eighty days, the application is void and the FQHC may resubmit the application to the agency, in which case, (a)(i) of this subsection does not apply.

(c) Retrospective change in scope.

(i) A retrospective change in scope of service rate adjustment application must state each qualifying event listed in subsection (1)(a)(i) of this section that supports its application and include twelve months of data documenting the cost change caused by the qualifying event. A retrospective change in scope is a change that took place in the past and the FQHC is seeking to adjust its rate based on that change.

(ii) If approved, a retrospective rate adjustment takes effect on the date the FQHC filed the application with the agency.

(3) **Supporting documentation.**

(a) To apply for a change in scope of service rate adjustment, the FQHC must include the following documentation in the application:

(i) A narrative description of the proposed change in scope;

(ii) A description of each cost center on the cost report that was or will be affected by the change in scope;

(iii) The FQHC's most recent audited financial statements, if audit is required by federal law;

(iv) The implementation date for the proposed change in scope; and

(v) Any additional documentation requested by the agency.

(b) A prospective change in scope of service rate adjustment application must also include projected medicaid cost report or projected medicare cost report with supplemental schedules necessary to identify the medicaid cost per visit for the twelve-month period following implementation of the change in scope.

(c) A retrospective change in scope of service rate adjustment application must also include the medicaid cost report or medicare cost report with supplemental schedules necessary to identify the medicaid cost per visit and encounter data for twelve months or the fiscal year following implementation of the proposed change in scope.

(4) **Review of the application.**

(a) Application processing.

(i) The agency must review the application for completeness, accuracy, and compliance with program rules.

(ii) Within sixty days of receiving the application, the agency must notify the FQHC of any deficient documentation or request any additional information that is necessary to process the application.

(iii) Within ninety days of receiving a complete application, the agency must send the FQHC:

(A) A decision stating whether it will implement a PPS rate change; and

(B) A rate-setting statement.

(iv) Failure to act within ninety days will mean that the change is considered denied by the agency and the FQHC

may appeal the decision as provided for in subsection (6) of this section.

(b) Determining rate for change in scope.

(i) The agency must set an interim rate for prospective changes in scope by adjusting the FQHC's existing rate by the projected average cost per encounter of any approved change. The agency will review the costs to determine if they are reasonable, and set a new interim rate based on the determined cost per encounter.

(ii) The agency must set an adjusted encounter rate for retrospective changes in scope by adjusting the FQHC's existing rate by the documented average cost per encounter of the approved change. Projected costs per encounter may be used if there are insufficient historical data to establish the rate. The agency will review the costs to determine whether they are reasonable, and set a new rate based on the determined cost per encounter.

(c) If the FQHC is paid under an alternative payment methodology (APM), any change in scope of service rate adjustment requested by the FQHC will modify the PPS rate in addition to the APM.

(d) The agency may delegate the duties related to application processing and rate setting to a third party. The agency retains final authority for making decisions related to changes in scope.

(5) **Post change in scope of services rate adjustment review.**

(a) If the change in scope application was retrospective (i.e., based on a year or more of actual encounter data), the agency may conduct a post change in scope rate adjustment review.

(b) If the change in scope application was prospective (i.e., based on less than a full year of actual encounter data), the FQHC must submit the following information to the agency within eighteen months of the effective date of the rate adjustment:

(i) Medicaid cost report or medicare cost report with supplemental schedules necessary to identify the medicaid cost per visit and encounter data for twelve consecutive months of experience following implementation of the change in scope; and

(ii) Any additional documentation requested by the agency.

(c) The agency will conduct the post change in scope review within ninety days of receiving the cost report and encounter data from the FQHC.

(d) If necessary, the agency will adjust the encounter rate within ninety days to ensure that the rate reflects the reasonable cost of the change in scope of services.

(e) A rate adjustment based on a post change in scope review will take effect on the date the agency issues its adjustment. The new rate will be prospective.

(f) If the FQHC fails to submit the post change in scope cost report or related encounter data, the agency must provide written notice to the center or clinic of the deficiency within thirty days.

(g) If the FQHC fails to submit required documentation within five months of this deficiency notice, the agency may reinstate the prechange in scope encounter rate going forward from the date the interim rate was established. Any overpayment to the FQHC may be recouped by the agency.

(6) **Appeals.** Appeals of agency action under this section are governed by WAC 182-502-0220, except that any rate change begins on the date the agency received the change in scope of services rate adjustment application.

WSR 15-05-030

PERMANENT RULES

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

(Operations Support and Services Division)

(Background Check Central Unit)

[Filed February 10, 2015, 10:32 a.m., effective March 13, 2015]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The purpose of this coordinated rule making is to move DSHS employee background check requirements into separate chapter 388-06B WAC. This filing also permanently adopts emergency rules filed under WSR 14-21-062. This rule making is intended to comply with federal and state law and to provide clarity for the affected individuals and hiring authorities.

Citation of Existing Rules Affected by this Order: Repealing WAC 388-06-0600, 388-06-0605, 388-06-0610, 388-06-0615, 388-06-0620, 388-06-0625, 388-06-0630, 388-06-0635, and 388-06-0640.

Statutory Authority for Adoption: RCW 43.43.832.

Other Authority: RCW 43.20A.710, 43.43.832, 43.43.-837.

Adopted under notice filed as WSR 15-01-094 on December 17, 2014.

Changes Other than Editing from Proposed to Adopted Version: Added chapter title for the new chapter 388-06B WAC.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 7, Amended 1, Repealed 9.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 7, Amended 1, Repealed 9.

Date Adopted: February 4, 2015.

Katherine I. Vasquez
Rules Coordinator

NEW SECTION

WAC 388-06-0030 What is the purpose of this chapter? (1) WAC 388-06-500 through 388-06-0540 defines when the one hundred twenty-day provisional hire is allowed by DSHS.

(2) WAC 388-06-0700 through 388-06-0720 describes the responsibilities of the background check central unit.

Chapter 388-06B WAC

DSHS Employee Background Checks

NEW SECTION

WAC 388-06B-0010 What is the purpose of this chapter? The purpose of this chapter is to establish standards for the department of social and health services to conduct background checks for department employees, applicants for employment, volunteers and student interns.

NEW SECTION

WAC 388-06B-0020 What definitions apply to this chapter? "Applicant" means a person who has applied for work in a department-covered position, including current employees, volunteers, students, or interns serving or working in a similarly situated position or any person who must meet state and federal background check requirements to work in a department-covered position.

"Background check central unit" means the program responsible for conducting background checks for the department of social and health services.

"Child or children" means any person under eighteen years of age.

"Department" means the department of social and health services.

"Department-covered position" means a position that has:

(1) Unsupervised access to vulnerable adults, juveniles, or children; or

(2) Access to the internal databases in the background check central unit and the division of disability determination services.

"Division of disability determination services" means the DSHS program contracted to perform medical determinations for the Social Security Administration in accordance with Social Security Administration regulations and requirements.

"DSHS" means the department of social and health services.

"Employee" means a permanent or non-permanent department of social and health services employee who is appointed to a department-covered position for any reason including but not limited to: transfer, promotion, demotion, elevation, layoff, reassignment, reallocation, and reversion.

"Juvenile" means a person under the age of twenty-one under the juvenile rehabilitation administration's (JRA) jurisdiction, or under the department of corrections' jurisdiction while placed in a JRA facility.

"Pending charge or pending action" means a charge or action awaiting a decision by a court or a civil adjudication proceeding. The term pending charge also includes specific types of court action where the defendant has agreed to certain conditions. Examples include a deferred prosecution or a stipulated order of continuance on an agreed condition. The department considers these types of cases on an individual case-by-case basis.

"Permanent employee" means a department employee who has successfully completed a Washington general service probationary period or Washington management service review period after appointment to a permanent position.

"Sensitive positions" means positions in the division of disability determination services and the background check central unit with access to federal databases or databases containing background check information.

"Unsupervised access" means a DSHS employee, volunteer or student intern who:

(1) Works, volunteers or serves in a setting, such as an institution, that provides residential services to vulnerable adults, juveniles and children;

(2) Works, volunteers or serves in a position where, during the course of his or her employment, the employee may transport, or visit the residence of, a vulnerable adult, juvenile or child; or

(3) Works, volunteers or serves in a position, other than one described in subsection (1) and (2) in this section, where the employee may be left alone with a vulnerable adult, juvenile or child. "Left alone" does not include the possibility of a public encounter, or public interaction.

"Vulnerable adult" means a person who is a client of the department who is:

(1) Sixty years of age or older who has the functional, mental, or physical inability to care for himself or herself; or

(2) Found incapacitated under chapter 11.88 RCW; or

(3) Developmentally disabled as defined under RCW 71A.10.020; or

(4) Admitted to any facility that is operated by the department; or

(5) Receiving services from a department contracted, authorized, certified, licensed, or individual provider, including those certified under chapter 70.96A RCW; or

(6) Receiving services through home health, hospice, or home care agencies required to be licensed under chapter 70.127 RCW; or

(7) Admitted for detoxification in a certified chemical dependency treatment facility in accordance with chapter 70.96A RCW; or

(8) A vulnerable adult as defined in chapter 74.34 RCW.

NEW SECTION

WAC 388-06B-0100 Must the DSHS secretary or designee conduct background checks on all employees in department-covered positions and applicants under consideration for a covered position? (1) The secretary of the department of social and health services or designee must conduct a background check, as authorized by statute, on all employees in covered positions; employees in sensitive posi-

tions, and applicants under final consideration for a covered position.

(2) A national fingerprint-based background check will be conducted if required by state law, federal regulations, or presidential directive.

NEW SECTION

WAC 388-06B-0200 What are the DSHS secretary's responsibilities in carrying out the requirements to conduct background checks? The DSHS secretary or designee will:

(1) Develop policies and guidelines pertaining to background checks. The department's background check policies and guidelines must minimally address the following:

(a) Process for identifying department-covered positions;

(b) Notification to employees and applicants that a background check is required for covered positions;

(c) When employees and applicants may be hired on a conditional basis pending the results of a background check;

(d) When a character, competence, and suitability review will be required to determine if the applicant and/or employee may have unsupervised access to vulnerable adults, juveniles and children;

(e) When rechecks may be initiated;

(f) What happens when a permanent DSHS employee is denied a department-covered position because of a background check or failure to authorize a background check to include:

(i) Employment options available when a permanent employee is disqualified from holding a department covered position;

(ii) Interim measures available while exploring employment options;

(iii) Process that will be used to identify non-covered department positions; and

(iv) Specific time-frame allowed for exploration of employment options prior to separation of a permanent employee.

(g) When an employee may request a review of a disqualification for employment in a covered position;

(2) Not further disseminate background check information unless authorized or required by law to do so; and

(3) Comply with public disclosure requirements and the rules of civil discovery when applicable.

NEW SECTION

WAC 388-06B-0300 What information is considered in a background check conducted by DSHS and how are the results of the background check used? (1) The background check information considered by the DSHS secretary or designee will include but is not limited to conviction records, pending charges, and civil adjudications as defined in RCW 43.43.830.

(2) The background information must be used by DSHS to determine the character, competence, and suitability of the applicant and/or employee to have unsupervised access to vulnerable adults, juveniles and children.

(3) If the applicant or employee's criminal history was reviewed in 2002 by DSHS through its background assessment review team (BART) process, and if DSHS determined the employee could remain in a covered position, the applicant or employee will not be disqualified based upon criminal history, including his or her conviction record, that was known and considered during the BART process.

(4) Background information that was the subject of a pardon, annulment, or other equivalent procedure will not disqualify an applicant and/or employee from having unsupervised access to vulnerable adults, juveniles and children.

(5) Results of a background check may be discoverable pursuant to the rules of civil discovery, or subject to disclosure pursuant to a public records request.

NEW SECTION

WAC 388-06B-0400 Must an employee or applicant authorize the secretary of the department of social and health services or designee to conduct a background check and what happens if the employee or applicant does not provide authorization? (1) An employee and/or applicant applying for or being considered for retention in a department-covered position must authorize the secretary of DSHS or designee to conduct a background check which may include fingerprinting when required by state or federal law or regulations.

(2) Failure to authorize the DSHS secretary or designee to conduct a background check shall disqualify an employee or applicant from consideration for any covered position including their current covered position.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 388-06-0600	Must the DSHS secretary or designee conduct background checks on all employees in covered positions and applicants under consideration for a covered position?
WAC 388-06-0605	What is a covered position?
WAC 388-06-0610	Who are vulnerable adults, juveniles or children?
WAC 388-06-0615	What is unsupervised access?
WAC 388-06-0620	What information is considered in a background check conducted by DSHS and what are the results of the background check used for?
WAC 388-06-0625	Must an employee and/or applicant authorize the secretary of the department of social and health services or designee to conduct a background check and what happens if the employee or applicant does not provide authorization?

WSR 15-05-047
PERMANENT RULES
HEALTH CARE AUTHORITY
(Washington Apple Health)

[Filed February 12, 2015, 2:51 p.m., effective March 15, 2015]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The permanent rule text clarifies policy in subsections (4)(a) and (7), and eliminates previous subsection (4)(c) to streamline the hearings process.

Citation of Existing Rules Affected by this Order: Amending WAC 182-527-2790.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Adopted under notice filed as WSR 15-01-114 on December 18, 2014.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 1, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 1, Repealed 0.

Date Adopted: February 12, 2015.

Jason R. P. Crabbe
Rules Coordinator

AMENDATORY SECTION (Amending WSR 13-19-038, filed 9/11/13, effective 10/12/13)

WAC 182-527-2790 Filing liens. (1) The medicaid agency or its designee may file liens to recover the cost of medical assistance or state-only funded long-term care services, or both, correctly paid on behalf of a client consistent with 42 U.S.C. 1396p ((~~and~~)), chapters 41.05A and 43.20B RCW, and 182-527 WAC.

(2) ((~~Prior to~~)) Before the agency or its designee ((~~filing~~)) files a lien under this section, the agency or its designee sends a notice via first class mail to:

(a) The address of the property and other assets subject to the lien;

(b) The probate estate's personal representative, if any;

(c) Any other person known to have title to the affected property ((~~and/or~~)) or to the decedent's heir(s) as defined by WAC 182-527-2730, or both; and

(d) The decedent's last known address or the address listed on the title, if any.

(3) The notice in subsection (2) of this section includes:

(a) The decedent's name, identification number, date of birth, and date of death;

(b) The amount of medical assistance or state-only funded long-term care services, or both, correctly paid on behalf of the deceased client that the agency or its designee seeks to recover;

(c) The agency's or its designee's intent to file a lien against the deceased client's property and other assets to recover the amount of medical assistance or state-only funded long-term care services, or both, correctly paid on behalf of the deceased client;

(d) The county in which the property and other assets are located; and

(e) The procedures to contest the agency's or its designee's decision to file a lien by applying for an administrative hearing.

(4) An administrative hearing ((~~only~~)) determines only:

(a) ((~~Whether the medical assistance or state-only funded long-term care services, or both, correctly paid on behalf of the decedent alleged by the agency's or its designee's notice is correct;~~)) The correctness of the dollar amount paid on behalf of the decedent for medical assistance or state-only funded long-term care services, or both; and

(b) Whether the decedent had legal title to the property((~~; and~~

~~(c) Whether a lien is allowed under the provisions of Title 42 U.S.C. Section 1396p (a) and (b)~~)).

(5) A request for an administrative hearing must:

(a) Be in writing;

(b) State the basis for contesting the lien;

(c) Be signed by the requester and must include the requester's address and telephone number; and

(d) Be served to the office of financial recovery (OFR) as described in WAC 182-527-2870, within twenty-eight calendar days of the date the agency or its designee mailed the notice.

(6) Upon receiving a request for an administrative hearing, the agency or its designee notifies persons known to have title to the property and other assets of the time and place of the administrative hearing.

(7) Persons known to have title to disputed assets ((~~must not be distributed~~)) cannot collect them while in litigation.

(8) An administrative hearing under this section is governed by chapters 34.05 RCW and 182-526 WAC and this section. If a provision in this section conflicts with a provi-

sion in chapter 182-526 WAC, the provision in this section governs.

(9) If an administrative hearing is conducted in accordance with this ((~~regulation~~)) section, and the final agency decision is issued, the agency or its designee ((~~only~~)) files a lien against the decedent's property and other assets ((~~only~~)) if upheld by the final agency decision.

(10) If no known title holder requests an administrative hearing, the agency or its designee files a lien twenty-eight calendar days after the date the agency or its designee mailed the notice described in subsection (2) of this section.

WSR 15-05-053
PERMANENT RULES
DEPARTMENT OF HEALTH
(Board of Optometry)

[Filed February 13, 2015, 10:00 a.m., effective March 16, 2015]

Effective Date of Rule: Thirty-one days after filing.

Purpose: WAC 246-851-235 Credits for cultural competency in clinical care, the new rule provides licensed optometrists optional credit for educational courses which increase cultural competency in health care. The rule addresses the increasing demand for health care practitioners to provide effective care for patients of diverse cultural and social origins. The rule does not change the continuing education credit requirements for optometrists.

Statutory Authority for Adoption: RCW 18.54.070.

Other Authority: RCW 43.70.615.

Adopted under notice filed as WSR 14-18-041 on August 27, 2014.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 1, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 1, Amended 0, Repealed 0.

Date Adopted: February 12, 2015.

Christopher Barry, OD
Chair, Board of Optometry

NEW SECTION

WAC 246-851-235 Credits for cultural competency in clinical care. (1) This section addresses the increasing demand for health care practitioners to provide effective care for patients of diverse cultural and social origins. All optometrists are encouraged to increase their knowledge and practice skills to provide effective care to all patients regardless of race, ethnicity, gender, or primary language.

(2) Continuing education credit will be granted for courses or materials related to the awareness of health disparities among different populations and the ability to effectively provide health services in cross cultural situations.

(3) No more than two credit hours will be granted under this section to any licensee in any two-year reporting period.

WSR 15-05-054
PERMANENT RULES
OFFICE OF INSURANCE COMMISSIONER

[Insurance Commissioner Matter No. R 2014-07—Filed February 13, 2015, 10:06 a.m., effective March 16, 2015]

Effective Date of Rule: Thirty-one days after filing.

Purpose: Ensure that the designated responsible licensed person (DRLP) of an insurance producer entity has sufficient authority and information to act in the capacity of a DRLP.

Statutory Authority for Adoption: RCW 48.02.060 and 48.17.005.

Other Authority: RCW 48.17.090 (3)(b).

Adopted under notice filed as WSR 15-02-059 on January 6, 2015.

A final cost-benefit analysis is available by contacting Jim Tompkins, P.O. Box 40258, Olympia, WA 98504-0258, phone (360) 725-7036, fax (360) 586-3109, e-mail rules coordinator@oic.wa.gov.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 1, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 1, Amended 0, Repealed 0.

Date Adopted: February 12, 2015.

Mike Kreidler
Insurance Commissioner

NEW SECTION

WAC 284-17-603 Designated responsible licensed person. The designated responsible licensed person (DRLP) must be given the necessary authority and information by the business entity that reasonably assures that the DRLP can cause or influence the entity's compliance with all applicable insurance laws or rules, or both of this state.